REMARKS

The Applicant respectfully requests reconsideration of claims 19-23, as amended, in light of the comments herein. Each independent claim (19, 21 and 23) has been amended; each dependent claim (20 and 22) is amended by virtue of depending on an amended claim.

In the Office Action, the Examiner rejected claim 23 under 35 U.S.C. 112, second paragraph. The offending language has been deleted from the claim.

Further, claims 19-23 were rejected under 35 U.S.C. 103(a) as being unpatentable over Freeman, Jr. (U.S. Pat. 6,012,035) in view of Tartar et al. (U.S. Patent 5,550,734). The Examiner cited Tartar for showing the feature of an insurance company billing an employer for premiums on a periodic basis. In the Applicant's system, the entity is aggregating all of the individual claims submitted by providers for health care services that the providers have rendered during a time period. In other words, each visit made by a patient to a doctor, each test performed, each physical therapy session attended, each hospital charge, each emergency room charge, etc. represents an individual claim; in the Applicant's system, the entity aggregates all such claims during a given time period and bills the total sum for these charges to the sponsor. This is of particular import in the context of an employer self-funded health care plan. Thus, this is radically different from what Tartar shows and suggests with respect to the insurance company billing an employer for premiums on a policy (as opposed to billing for health care claims). The Applicant has amended the independent claims to more particularly point out this novel and nonobvious aspect of the Applicant's method and system.

In addition, neither Freeman nor Tartar suggest the combining of their teachings. The Applicant further notes that the claims recite additional features not shown or

suggested by Freeman or Tartar or a combination thereof. The method described by the Examiner that results from the combination of Freeman and Tartar has the following steps:

- Doctors report to insurance company;
- Employer pays insurancy company for premiums;
- Insurance company reports to patient what is owed;
- Insurance company collects payment from employer in the form of premiums;
- Insurance company pays providers;
- Additional payment may be collected from patient.

In Freeman, this last step in which payment is collected from the patient, is described as the Examiner noted at column 8, lines 33-36). More specifically, Freeman describes that "...the patient...[pays] their share of the claim amount to the bank." The bank is not the same entity as the insurance company. Thus, in the method described by Freeman and as interpreted by the Examiner, the patient gets a bill from the insurance company but then pays the bank. As the Examiner has noted in earlier Office Actions in this matter, Freeman does also note that the bank generates a statement that is sent to the patient. Thus, the patient receives two communications: a statement from the bank and an explanation of benefits from the insurance company. This use of two entities for billing and collection, instead of one, leads to confusion and complications in the billing and collections process. It is these sorts of inefficiencies that the Applicant's system and method, as described and claimed, is designed to reduce. Specifically, in claim 23, the Applicant recite that the "system operates without the health care providers sending bills, statements or explanation of benefits to the patients and without the sponsor sending bills, statements or explanation of benefits to the

patient." Neither Freeman nor Tartar show or suggest any change to the traditional method by which both providers and insurance companies send bills, statements or EOBs to the patient or where the patient receives only one communication regarding the services rendered.

CONCLUSION

The Applicant submits that the pending claims are in condition for allowance and a notice to the effect is solicited. The Examiner is invited to contact the Applicant's attorney at the below-noted telephone number if allowance of this case would be assisted thereby.

Respectfully submitted,
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Version with Markings to Show Changes Made

(Amendment submitted August 21, 2003)

19. (Amended) A method of health care benefit billing, payment and reporting in a health care plan that is self-funded by a sponsor comprising the steps of:

a) multiple providers providing services to multiple patients covered by a ~~sponsored~~ health benefit plan self-funded by a sponsor and reporting the services to a first entity;

b) said entity reporting to sponsor on a periodic basis the aggregate amount owed by sponsor for health care services rendered by said providers for the covered patients during the period;

c) said entity reporting to patient on a periodic basis the amount owed by patient for provider services rendered during a predetermined period;

d) said entity collecting payment from the sponsor;

e) said entity paying said provider for services within a predetermined time period after the provisions of services, regardless of whether the entity has received payment from the patient;

f) said entity collecting payment from the patient.

20. (Unchanged) A method according to claim 19, further comprising the step of:

g) said entity collecting a lump sum from said sponsor for the billed aggregate amount owed for the period.

21. (Amended) A method of health care benefit billing, payment and reporting in a health care plan that is self-funded by a sponsor, comprising the steps of:

a) plan sponsor providing a self-funded health benefit plan to an employee and to the family members of the employee;

b) multiple providers providing services to multiple patients covered by a sponsored health benefit plan and reporting the services to a first entity;

c) said entity reporting to sponsor on a periodic basis the aggregate amount owed by sponsor for health care services rendered by said providers for the covered patients during the period;

d) said entity reporting to employees on a periodic basis the amount owed by employee for provider services rendered during a predetermined period on behalf of the employee and the employee's covered family members, said report to employee being sorted by family member;

e) said entity collecting payment from the sponsor;

f) said entity paying said provider for services within a predetermined time period after the provisions of services, regardless of whether the entity has received payment from the patient;

g) said entity collecting payment from the patient.

22. (Unchanged) A method according to claim 21, wherein said report to employee includes plain language descriptions of services rendered.

23. (Amended) A system for administering a ~~sponsored~~ health benefit plan self-funded by a sponsor comprising:

a) an adminstrator;

b) means for health care providers to report periodically to the administrator all of the services rendered under the health benefit plan for all covered patients during a given time period;

c) means for the administrator to adjudicate each claim and to determine the amount owed on the claim by the patient and by the plan sponsor;

d) means for the administrator to report to the patient on a periodic basis all of the services rendered for that patient during a given time period;

e) means for the administrator to report to the plan sponsor on a periodic basis all of the health care services rendered by providers for all covered patients during a given time period and to identify the amount owed by the plan sponsor for these claims;

f) means for the sponsor to pay the administrator;

g) means for the patient to pay the administrator; and

h) whereby said system operates without the health care providers sending bills, statements or explanation of benefits to the patients and without the sponsor sending bills, statements or explanation of benefits to the patient~~, and whereby said system operates without any other entities involved in the system besides the administrator, the plan sponsor, the health care providers, and the patients~~.